

		FOR OHF USE					

LL 1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0039768</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lexington of Lake Zurich</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>930 South Rand Road</u> <u>Lake Zurich</u> <u>60047</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Lake</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(847) 726-1200</u> Fax # <u>(847) 726-1265</u>		(Type or Print Name) _____	
IDPA ID Number: <u>363748801001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>8/20/94</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 05/30/03

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>213</u>	<u>76,255</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>213</u>	<u>76,255</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,805</u>	<u>5,244</u>	<u>9,505</u>	<u>36,554</u>	8
9	SNF/PED					9
10	ICF	<u>21,941</u>	<u>4,576</u>	<u>295</u>	<u>26,812</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,746</u>	<u>9,820</u>	<u>9,800</u>	<u>63,366</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.10%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐ Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/20/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date New construction NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 70 and days of care provided 9,080Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	287,006	38,240	11,339	336,585		336,585		336,585			1
2	Food Purchase		245,030		245,030		245,030	(10,948)	234,082			2
3	Housekeeping	272,880	27,236		300,116		300,116	354	300,470			3
4	Laundry	58,274	18,836		77,110		77,110	(5,486)	71,624			4
5	Heat and Other Utilities			193,809	193,809		193,809	3,545	197,354			5
6	Maintenance	69,117		110,321	179,438		179,438	2,606	182,044			6
7	Other (specify):*											7
8	TOTAL General Services	687,277	329,342	315,469	1,332,088		1,332,088	(9,929)	1,322,159			8
	B. Health Care and Programs											
9	Medical Director			25,500	25,500		25,500		25,500			9
10	Nursing and Medical Records	2,921,867	210,509	187,145	3,319,521		3,319,521		3,319,521			10
10a	Therapy			747,181	747,181		747,181		747,181			10a
11	Activities	175,318	20,591	4,310	200,219		200,219		200,219			11
12	Social Services	64,059		2,188	66,247		66,247		66,247			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,161,244	231,100	966,324	4,358,668		4,358,668		4,358,668			16
	C. General Administration											
17	Administrative	166,178		404,756	570,934		570,934	(404,756)	166,178			17
18	Directors Fees											18
19	Professional Services			59,290	59,290		59,290	7,268	66,558			19
20	Dues, Fees, Subscriptions & Promotions			47,558	47,558		47,558	776	48,334			20
21	Clerical & General Office Expenses	528,704	42,494	24,415	595,613		595,613	20,896	616,509			21
22	Employee Benefits & Payroll Taxes			617,670	617,670		617,670	72,802	690,472			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,580	4,580		4,580	2,690	7,270			24
25	Other Admin. Staff Transportation			182	182		182	8,884	9,066			25
26	Insurance-Prop.Liab.Malpractice			198,117	198,117		198,117	3,479	201,596			26
27	Other (specify):*											27
28	TOTAL General Administration	694,882	42,494	1,356,568	2,093,944		2,093,944	(287,961)	1,805,983			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,543,403	602,936	2,638,361	7,784,700		7,784,700	(297,890)	7,486,810			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			33,031	33,031		33,031	235,981	269,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,061	38,061		38,061	356,792	394,853			32
33	Real Estate Taxes							132,968	132,968			33
34	Rent-Facility & Grounds			1,327,724	1,327,724		1,327,724	(1,327,724)				34
35	Rent-Equipment & Vehicles			7,002	7,002		7,002	3,857	10,859			35
36	Other (specify):*											36
37	TOTAL Ownership			1,405,818	1,405,818		1,405,818	(598,126)	807,692			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		245,429		245,429		245,429		245,429			39
40	Barber and Beauty Shops			29,364	29,364		29,364		29,364			40
41	Coffee and Gift Shops			6,762	6,762		6,762		6,762			41
42	Provider Participation Fee			114,383	114,383		114,383		114,383			42
43	Other (specify):* Nonallowable Costs			65,245	65,245		65,245	(65,245)				43
44	TOTAL Special Cost Centers		245,429	215,754	461,183		461,183	(65,245)	395,938			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,543,403	848,365	4,259,933	9,651,701		9,651,701	(961,261)	8,690,440			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(325)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(5,486)	4		8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(2)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,290)	43		13
14 Non-Care Related Interest	(30,500)	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(921)	43		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(90)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(34,388)	43		24
25 Fund Raising, Advertising and Promotional	(15,600)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See attached Schedule A	(17,030)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,632)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(855,629)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (855,629)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (961,261)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Lake Zurich

Provider # 0039768

1/1/03 - 12/31/03

Schedule A

Schedule VI. Adjustment detail

Line 29, Other

Description	Amount	Reference
Disallow nonallowable radiology	(8,957.00)	43
Disallow nonallowable laboratory	(3,858.00)	43
Nonallowable collections	(2,958.00)	19
Deferred maintenance amort.	351.00	6
Offset miscellaneous income	(1,181.00)	21
Cash over/under	(141.00)	43
Disallow out of period legal fees	(286.00)	19
Total	<u>(17,030.00)</u>	

See Accountants' Compilation Report

Lexington of Lake Zurich

ID# 0039768

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(325)	0	0	0	0	0	0	0	0	0	0	(325)	2
3	Housekeeping	0	0	354	0	0	0	0	0	0	0	0	354	3
4	Laundry	(5,486)	0	0	0	0	0	0	0	0	0	0	(5,486)	4
5	Heat and Other Utilities	0	0	3,545	0	0	0	0	0	0	0	0	3,545	5
6	Maintenance	0	0	2,255	0	0	0	0	0	0	0	0	2,255	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,811)	0	6,154	0	0	0	0	0	0	0	0	343	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(404,756)	0	0	0	0	0	0	0	(404,756)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,500	10,512	0	0	0	0	0	0	0	0	14,012	19
20	Fees, Subscriptions & Promotions	0	0	776	0	0	0	0	0	0	0	0	776	20
21	Clerical & General Office Expenses	0	110	21,967	0	0	0	0	0	0	0	0	22,077	21
22	Employee Benefits & Payroll Taxes	0	0	62,179	0	0	0	0	0	0	0	0	62,179	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,690	0	0	0	0	0	0	0	0	2,690	24
25	Other Admin. Staff Transportation	0	0	0	8,884	0	0	0	0	0	0	0	8,884	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,479	0	0	0	0	0	0	0	3,479	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	3,610	98,124	(392,393)	0	0	0	0	0	0	0	(290,659)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,811)	3,610	104,278	(392,393)	0	0	0	0	0	0	0	(290,316)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	206,988	0	28,993	0	0	0	0	0	0	0	235,981	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30,502)	386,971	0	323	0	0	0	0	0	0	0	356,792	32
33	Real Estate Taxes	0	127,724	0	1,744	0	0	0	0	0	0	0	129,468	33
34	Rent-Facility & Grounds	0	(1,327,724)	0	0	0	0	0	0	0	0	0	(1,327,724)	34
35	Rent-Equipment & Vehicles	0	0	0	3,857	0	0	0	0	0	0	0	3,857	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(30,502)	(606,041)	0	34,917	0	0	0	0	0	0	0	(601,626)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(52,289)	0	0	0	0	0	0	0	0	0	0	(52,289)	43
44	TOTAL Special Cost Centers	(52,289)	0	0	0	0	0	0	0	0	0	0	(52,289)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(88,602)	(602,431)	104,278	(357,476)	0	0	0	0	0	0	0	(944,231)	45

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	33.33%			Lexington Health Care Systems of		
John Samatas Discretionary Trust	33.33%	See attached Schedule B		Lake Zurich Ltd Ptsp	Lake Zurich	Real estate ptsp.
Cynthia Thiem Discretionary Trust	33.34%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 Professional fees	\$	Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	\$ 3,500	\$ 3,500 1
2	V	21 Bank charges		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	110	110 2
3	V	30 Depreciation		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	206,988	206,988 3
4	V	32 Interest expense		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	383,394	383,394 4
5	V	32 Amortization of mortgage cost		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	3,577	3,577 5
6	V	33 Property taxes		Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**	127,724	127,724 6
7	V	34 Rental expense	1,327,724	Lexington Health Care Systems of Lake Zurich Ltd Ptsp	**		(1,327,724) 7
8	V						8
9	V						9
10	V						10
11	V	** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington Health Care Systems of Lake Zurich Limited Partnership.					11
12	V						12
13	V						13
14	Total		\$ 1,327,724			\$ 725,293	\$ * (602,431) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 354	\$ 354 15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,481	3,481 16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	64	64 17
18	V	6 Repairs & maintenance		Royal Management Corp.	**	2,190	2,190 18
19	V	6 Scavenger & exterminating		Royal Management Corp.	**	65	65 19
20	V	19 Computer consultant & supplies		Royal Management Corp.	**	7,920	7,920 20
21	V	19 Professional fees		Royal Management Corp.	**	2,592	2,592 21
22	V	20 Advertising - help wanted		Royal Management Corp.	**	176	176 22
23	V	20 Dues & subscriptions		Royal Management Corp.	**	600	600 23
24	V	21 Bank charges		Royal Management Corp.	**	3,045	3,045 24
25	V	21 Office supplies & printing		Royal Management Corp.	**	6,955	6,955 25
26	V	21 Postage		Royal Management Corp.	**	3,128	3,128 26
27	V	21 Telephone		Royal Management Corp.	**	8,839	8,839 27
28	V	22 FICA		Royal Management Corp.	**	28,084	28,084 28
29	V	22 FUTA		Royal Management Corp.	**	504	504 29
30	V	22 SUTA		Royal Management Corp.	**	873	873 30
31	V	22 Insurance - W/C		Royal Management Corp.	**	532	532 31
32	V	22 Insurance - hospitalization		Royal Management Corp.	**	27,755	27,755 32
33	V	22 401(k) and other emp. benefits		Royal Management Corp.	**	4,431	4,431 33
34	V	24 Travel & seminar		Royal Management Corp.	**	2,690	2,690 34
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Lake Zurich, Inc. Own 100% of Royal Management Corp.					
39	Total		\$			\$ 104,278	\$ * 104,278 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	25 Auto expense	\$	Royal Management Corp.	**	\$ 8,884	\$ 8,884
16	V	26 Insurance general		Royal Management Corp.	**	3,479	3,479
17	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,082	3,082
18	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	7,205	7,205
19	V	30 Depreciation - equipment		Royal Management Corp.	**	18,706	18,706
20	V	32 Interest		Royal Management Corp.	**	323	323
21	V	33 Property taxes		Royal Management Corp.	**	1,744	1,744
22	V	35 Equipment rental		Royal Management Corp.	**	3,857	3,857
23	V	17 Management fees	404,756	Royal Management Corp.	**		(404,756)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Lake Zurich, Inc. Own 100% of Royal Management Corp.					
39	Total		\$ 404,756			\$ 47,280	\$ * (357,476)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Lake Zurich

Provider # 0039768

1/1/03 - 12/31/03

Schedule B

VII. Related Parties

Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Lexington of Lake Zurich # 0039768 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	4	10%	Salary	\$ 32,143	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33%	See Schedule C	2	8%	Salary	20,089	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	13%	Salary	16,071	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10%	Salary	4,821	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	10%	Salary	12,254	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 85,378		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Lake Zurich**Provider # 0039768****1/1/03 - 12/31/03****Schedule C**

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	17,021	27,234	13,617	4,085	10,383	72,340
Lexington Health Care Center of Chicago Ridge, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Elmhurst, Inc.	14,844	23,751	11,875	3,563	9,055	63,088
Lexington Health Care Center of LaGrange, Inc.	10,787	17,259	8,629	2,589	6,580	45,844
Lexington Health Care Center of Lombard, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Orland Park, Inc.	26,721	42,748	21,376	6,413	16,298	113,556
Lexington Health Care Center of Schaumburg, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Streamwood, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Wheeling, Inc.	21,870	34,993	17,496	5,249	13,342	92,950
Total	179,911	287,857	143,929	43,179	109,746	764,622

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Lake Zurich# 0039768 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.
 Street Address 665 W. North Avenue, Suite 500
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	\$ 3,521	\$ 74,095		354	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	34,652	74,095		3,481	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	635	74,095		64	3
4	6	Repairs & maintenance	Bed Days	737,665	10	21,802	74,095		2,190	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	648	74,095		65	5
6	19	Computer consultant & supplies	Bed Days	737,665	10	78,852	74,095		7,920	6
7	19	Professional fees	Bed Days	737,665	10	25,806	74,095		2,592	7
8	20	Advertising - help wanted	Bed Days	737,665	10	1,748	74,095		176	8
9	20	Dues & subscriptions	Bed Days	737,665	10	5,976	74,095		600	9
10	21	Bank charges	Bed Days	737,665	10	30,319	74,095		3,045	10
11	21	Office supplies & printing	Bed Days	737,665	10	69,243	74,095		6,955	11
12	21	Postage	Bed Days	737,665	10	31,145	74,095		3,128	12
13	21	Telephone	Bed Days	737,665	10	87,995	74,095		8,839	13
14	22	FICA	Bed Days	737,665	10	279,595	74,095		28,084	14
15	22	FUTA	Bed Days	737,665	10	5,021	74,095		504	15
16	22	SUTA	Bed Days	737,665	10	8,695	74,095		873	16
17	22	Insurance - W/C	Bed Days	737,665	10	5,294	74,095		532	17
18	22	Insurance - hospitalization	Bed Days	737,665	10	276,319	74,095		27,755	18
19	22	401(k) and other emp. benefits	Bed Days	737,665	10	44,113	74,095		4,431	19
20	24	Travel & seminar	Bed Days	737,665	10	26,781	74,095		2,690	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,038,160	\$		\$ 104,278	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	\$ 88,444	\$ 74,095	\$ 8,884	1
2	26	Insurance - general	Bed Days	737,665	10	34,634	74,095	3,479	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	30,679	74,095	3,082	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	71,727	74,095	7,205	4
5	30	Depreciation - equipment	Bed Days	737,665	10	186,226	74,095	18,706	5
6	32	Interest	Bed Days	737,665	10	3,219	74,095	323	6
7	33	Property taxes	Bed Days	737,665	10	17,360	74,095	1,744	7
8	35	Equipment rental	Bed Days	737,665	10	38,401	74,095	3,857	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 470,690	\$	\$ 47,280	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

01/01/03

Ending:

12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense									
		YES	NO				Original	Balance												
	A. Directly Facility Related																			
	Long-Term																			
1	Lexington Financial						\$		\$			\$							1	
2	Services II, L.L.C.	X		Mortgage	\$49,259.00	12/29/98		6,478,000		5,584,108	12/29/08	0.0675					383,394		2	
3																			3	
4																			4	
5																			5	
	Working Capital																			
6	Shareholders	X		Working Capital	None	Varies		270,033		1,522,282	Demand	0.0200					30,500		6	
7	LaSalle Bank, N.A.		X	Line of Credit	Varies	12/01/02		750,000			11/30/04	Prime					7,561		7	
8																			8	
9	TOTAL Facility Related				\$49,259.00		\$	7,498,033	\$	7,106,390				\$			421,455		9	
	B. Non-Facility Related*																			
10									Amortization of loan costs								3,577		10	
11									Interest income offset								(2)		11	
12									Allocated from management company								323		12	
13									Nonallowable shareholder interest								(30,500)		13	
14	TOTAL Non-Facility Related						\$		\$						\$		(26,602)		14	
15	TOTALS (line 9+line14)						\$	7,498,033	\$	7,106,390						\$		394,853		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lexington of Lake Zurich**# **0039768** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.			\$ 150,000	1
		Allocated from management company	1,744	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002		\$ 136,724	2
3. Under or (over) accrual (line 2 minus line 1).			\$ (11,532)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 141,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$ 3,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 132,968	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	111,454	8	
	1999	112,784	9	
	2000	120,166	10	
	2001	141,884	11	
	2002	136,724	12	
2002 taxes:	136,724			
Estimated increase (3 %)	1.03			
Estimated 2003 taxes:	140,826			
Use:	141,000			

		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Lake Zurich COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0039768

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-28-100-020</u>	<u>Land & Building</u>	\$ <u>136,723.74</u>	\$ <u>136,723.74</u>
2. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$ _____	\$ _____
3. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>212,239.00</u>	\$ <u>1,744.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>348,962.74</u>	\$ <u>138,467.74</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

See Accountants' Compilation Report

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 78,901
 B. General Construction Type:
 Exterior Brick
 Frame Steel
 Number of Stories 3

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	250,344	1990	\$ 495,000	1
2	Allocated from management company			16,025	2
3	TOTALS	250,344		\$ 511,025	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	203	1994	1994	\$ 6,418,908	\$	40	\$ 160,473	\$ 160,473	\$ 1,497,746
5	10	2003	2003						
6									
7									
8									
Improvement Type**									
9	Land Improvements	1994	1994	10,701		10	1,070	1,070	10,166
10	Land Improvements	1994	1994	13,329	1,333	10	1,333		12,664
11	Leasehold Improvements	1994	1994	4,737	316	15	316		3,000
12	Leasehold Improvements	1995	1995	4,005	267	15	267		2,270
13	Land Improvements	1995	1995	3,221		10	322	322	2,738
14	Building Improvements	1995	1995	3,019		40	75	75	643
15	Building Improvements	1995	1995	64,500	1,654	39	1,654		14,404
16	Patio	1996	1996	1,168	78	15	78		584
17	Compressor	1996	1996	5,145	514	10	514		3,858
18	Road sidewalk	1997	1997	18,094		20	905	905	5,880
19	Foundation/Sprinkler	1997	1997	2,068	59	35	59		384
20	Flagpoles	1997	1997	1,573	105	15	105		682
21	Basement rehab	1998	1998	12,867	1,287	10	1,287		7,077
22	MDS Telnet wiring	1998	1998	3,365	337	10	337		1,851
23	Flag Pole	1998	1998	787	52	15	52		288
24	Resurface/restripe parking lot	1998	1998	4,976	498	10	498		2,738
25	Transfer 10 beds from shelter care	1998	1998	2,259	56	40	56		291
26	1st floor lobby tile	1999	1999	12,153	1,216	10	1,216		5,470
27	Parking lot repair	2000	2000	3,740	374	10	374		1,309
28	Roof repair	2000	2000	10,770	1,077	10	1,077		3,769
29	Automatic door	2000	2000	1,300	130	10	130		455
30	Kitchen rehab	2000	2000	16,887	1,689	10	1,689		5,911
31	Compressor	2001	2001	4,350	435	10	435		1,087
32	Boiler vent	2001	2001	3,228	323	10	323		807
33	Fire pump	2001	2001	1,766	177	10	177		442
34	Kitchen rehab	2001	2001	721	72	10	72		180
35	Elevator infrared curtains	2001	2001	4,500	450	10	450		1,125
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	Leasehold improvements - management company	1995	\$ 10,157	\$	35	\$ 301	\$ 301	\$ 2,467	37
38	Leasehold improvements - management company	1996	8,266		35	245	245	1,771	38
39	Leasehold improvements - management company	1989	285		31	8	8	143	39
40	HVAC - management company	1998	214		35	6	6	37	40
41	Offices - management company	1999	540		35	16	16	69	41
42	Land improvements - management company	2002	25,257		15	748	748	3,227	42
43	Building - management company	2002	196,500		40	5,823	5,823	9,416	43
44	HVAC, electrical, security system - management company	2003	1,948		30	58	58	50	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,877,304	\$ 12,499		\$ 182,549	\$ 170,050	\$ 1,604,999	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 594,615	\$ 19,127	\$ 63,270	\$ 44,143	3-10 yrs	\$ 516,147	71
72	Current Year Purchases	20,837	1,405	1,405		3-10 yrs	1,405	72
73	Fully Depreciated Assets							73
74	Allocated from management company	179,861		18,706	18,706		59,608	74
75	TOTALS	\$ 795,313	\$ 20,532	\$ 83,381	\$ 62,849		\$ 577,160	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			30,055		3,082	3,082		23,996	79
80	TOTALS			\$ 30,055	\$	\$ 3,082	\$ 3,082		\$ 23,996	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,213,697	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,031	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 269,012	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 235,981	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,206,155	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Therapy Room Rehab	\$ 13,326	92
93			93
94			94
95		\$ 13,326	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ **YES** ☐ **NO** **Terms:** _____

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 10,859 Description: Copier: \$6,732; Fax: \$270 \$; Allocation from management company: \$3857
(Attach a schedule detailing the breakdown of movable equipment)

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. **/2004** **\$**

13. /2005 \$

14. /2006 \$

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	3,882	\$ 284,564	\$	3,882	\$ 284,564	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,893	56,100		1,893	56,100	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		6,954	406,517		6,954	406,517	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				245,429		245,429	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	12,729	\$ 747,181	\$ 245,429	12,729	\$ 992,610	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Lexington of Lake Zurich

0039768

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 90,962	\$ 93,097	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 394,200)	1,483,461	1,483,461	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,910	52,910	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	19,786	19,786	8
9	Other(specify): Escrows		31,591	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,647,119	\$ 1,680,845	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,566	8,566	12
13	Land		511,025	13
14	Buildings, at Historical Cost		6,418,908	14
15	Leasehold Improvements, at Historical Cost	180,195	458,396	15
16	Equipment, at Historical Cost	174,023	825,368	16
17	Accumulated Depreciation (book methods)	(171,774)	(2,206,155)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attached Schedule E	13,326	66,989	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 204,336	\$ 6,083,097	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,851,455	\$ 7,763,942	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 403,088	\$ 403,088	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,522,282	1,522,282	29
30	Accrued Salaries Payable	197,971	197,971	30
31	Accrued Taxes Payable (excluding real estate taxes)	52,813	52,813	31
32	Accrued Real Estate Taxes(Sch.IX-B)		141,000	32
33	Accrued Interest Payable		31,411	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	458,159	108,764	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,634,313	\$ 2,457,329	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,584,108	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,584,108	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,634,313	\$ 8,041,437	46
47	TOTAL EQUITY (page 18, line 24)	\$ (782,858)	\$ (277,495)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,851,455	\$ 7,763,942	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington of Lake Zurich
Provider # 0039768
1/1/03 - 12/31/03

Schedule E

XV. Balance Sheet

B. Long Term Assets

23. Other Long Term Assets

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Construction in progress	13,326	13,326
Unamortized mortgage costs		53,663
Total line 23	<u>13,326</u>	<u>66,989</u>

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	349,395	-
Accrued management fees	31,984	31,984
Accrued 401 (k) contribution	7,676	7,676
Accrued Wage Assignment	320	320
Other accrued expenses	64,592	64,592
Due to related parties	4,192	4,192
Total line 36	<u>458,159</u>	<u>108,764</u>

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Investment Income in Lexington Financial Services II, LLC	481
Miscellaneous Income	1,181
Total line 28	<u>1,662</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (819,531)	1
2	Restatements (describe):		2
3			3
4			4
5	Rounding	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (819,530)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,672	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 36,672	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (782,858)	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,879,485	1
2	Discounts and Allowances for all Levels	(877,097)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,002,388	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,244,780	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,244,780	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,842	12
13	Barber and Beauty Care	31,992	13
14	Non-Patient Meals	325	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	308,298	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,695	19
20	Radiology and X-Ray	11,694	20
21	Other Medical Services	48,209	21
22	Laundry	5,486	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 439,541	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	1,662	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,662	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,688,373	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,332,088	31
32	Health Care	4,358,668	32
33	General Administration	2,093,944	33
B. Capital Expense			
34	Ownership	1,405,818	34
C. Ancillary Expense			
35	Special Cost Centers	346,800	35
36	Provider Participation Fee	114,383	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,651,701	40
41	Income before Income Taxes (line 30 minus line 40)**	36,672	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 36,672	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files a cash basis tax return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lexington of Lake Zurich**# **0039768**Report Period Beginning: **01/01/03**Ending: **12/31/03**

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,625	1,923	\$ 91,059	\$ 47.35	1
2	Assistant Director of Nursing	2,754	2,938	84,377	28.72	2
3	Registered Nurses	30,703	33,162	969,833	29.25	3
4	Licensed Practical Nurses	12,862	13,763	348,430	25.32	4
5	Nurse Aides & Orderlies	99,973	104,141	1,294,883	12.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,447	12,218	133,285	10.91	8
9	Activity Director	1,652	1,808	26,070	14.42	9
10	Activity Assistants	14,903	15,665	149,248	9.53	10
11	Social Service Workers	3,184	3,454	64,059	18.55	11
12	Dietician	1,707	1,747	25,159	14.40	12
13	Food Service Supervisor	2,037	2,077	28,209	13.58	13
14	Head Cook	2,029	2,201	23,477	10.67	14
15	Cook Helpers/Assistants	12,002	12,937	100,287	7.75	15
16	Dishwashers	16,874	18,007	109,874	6.10	16
17	Maintenance Workers	3,662	4,206	69,117	16.43	17
18	Housekeepers	38,419	41,399	272,880	6.59	18
19	Laundry	9,176	9,645	58,274	6.04	19
20	Administrator	1,299	1,770	80,800	45.65	20
21	Assistant Administrator					21
22	Other Administrative	648	651	85,378	131.15	22
23	Office Manager					23
24	Clerical	24,246	27,451	528,704	19.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	291,202	311,163	\$ 4,543,403 *	\$ 14.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	218	\$ 11,339	L1, C3	35
36	Medical Director	18	25,500	L9, C3	36
37	Medical Records Consultant	14	850	L10, C3	37
38	Nurse Consultant	56	1,406	L10, C3	38
39	Pharmacist Consultant	12	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	90	4,310	L11, C3	44
45	Social Service Consultant	48	2,188	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	456	\$ 46,793		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,087	\$ 62,597	L10, C3	50
51	Licensed Practical Nurses	3,383	84,578	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,470	\$ 147,175		53

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

0039768

Report Period Beginning: 01/01/03

Page 21

Ending: 12/31/03

Facility Name & ID Number

Lexington of Lake Zurich

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Samatas	Admin/Plant Ops	33.33%	\$ 20,089
James Samatas	Administrative	33.33%	32,143
Cynthia Thiem	Administrative	33.34%	16,071
George Samatas	Administrative	0.00%	4,821
Jason Samatas	Administrative	0.00%	12,254
See attached Schedule F1			80,800
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 166,178

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	\$ 404,756
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 404,756

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) Administration	\$ 450
Altschuler, Melvoin & Glasser LLP	Accounting	14,848
American Express Tax & Bus. Svcs.	Accounting	5,511
James Samatas	Legal	50
Personnel Planners	U/C Consulting	1,654
Carol Jeschke	Staffing Consultant	838
Sachnoff & Weaver	Legal	20,778
See attached Schedule F2		15,161
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 59,290

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 66,631
Unemployment Compensation Insurance	33,326
FICA Taxes	331,030
Employee Health Insurance	232,704
Employee Meals	10,623
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	10,207
Other employee benefits	5,951
TOTAL (agree to Schedule V, line 22, col.8)	\$ 690,472

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	44,482
Health Care Worker Background Check (Indicate # of checks performed 41)	500
Miscellaneous Licenses & Permits	1,055
Miscellaneous Dues & Subs	1,697
Allocation from management company	600
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 48,334

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	4,580
Seminar Expense	
Allocation from management company	2,690
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,270

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lake Zurich, Inc.

Provider # 0039768

1/1/03 - 12/31/03

Schedule F1

XIX. Support Schedules

A. Administrative Salaries

Name	Function	Ownership	Amount
Remedios, Panlilio-Newman	Administrator	0.00%	55,919
Steven Klekamp	Administrator	0.00%	1,659
Connie Sherman	Administrator	0.00%	23,222
Total			80,800

See accountants' compilation report.

Lexington Health Care Center of Lake Zurich, Inc.**Provider # 0039768****1/1/03 - 12/31/03****Schedule F2**

XIX. Support Schedules

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Katten, Muchin, Zavis and Rosenman	Legal	4,290
Harris, Kessler & Goldstein	Legal	1,039
Gilson, Labus & Silverman	Accounting	71
Nyemaster, Goode, Voigts, West, Hansel & O'Leary	Legal	850
Advanced Answers on Demand	Computer Services	2,652
Administar	Computer Services	378
Gigatrend	Computer Services	195
eHealth Solutions	Computer Services	1,080
Kraku Business Computer Systems	Computer Services	493
Information Controls Inc.	Computer Services	1,155
Garbowski & Green	Collections	868
Various	Consulting Services	2,090
		<hr/> 15,161
Total, Agrees to Schedule V, Line 19, Column 3		<hr/> <hr/> 59,290
Allocated from management co.		
American Express Tax & Business Services	Accounting	566
Gilson, Labus and Silverman	Accounting	49
James Samatas	Legal	70
Katten, Muchin, Zavis and Rosenman	Legal	66
Sachnoff and Weaver	Legal	513
ING / Pension Administrators	401 (k) Administration	692
Various	Consulting	636
Various	Computer consulting	7,920
Allocated from building partnership		
JSO Valuation Group	Appraisal fees	3,500
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(2,090)
Grabowski & Green	Legal-collection fees	(868)
Katten, Muchin, Zavis and Rosenman	Legal-out of period	(286)
Reclassifications		
JSO Valuation Group	Appraisal fees	(3,500)
Total, Agrees to Schedule V, Line 19, Column 8		<hr/> <hr/> 66,558

See accountants' compilation report.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Deferred maintenance	9/00	\$ 2,103	3 yrs	\$ 350	\$ 701	\$ 701	\$ 351	\$	\$	\$	\$	\$
2													
3													
4													
5													
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18													
19													
20	TOTALS		\$ 2,103		\$ 350	\$ 701	\$ 701	\$ 351	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

STATE OF ILLINOIS

0039768

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 49,634 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 114,383
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 10,623 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 325
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Lexington of Lake Zurich

12:22 PM 11/4/2005

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE C	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-961,261	equal to	-961,261	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	394,853	equal to	394,853	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	132,968	equal to	132,968	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org. N/A		equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	269,012	equal to	269,012	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N:	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	10,859	equal to	10,859	0	O.K.	Pg14 J30+N	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	747,181	equal to	747,181	0	O.K.	Pg16 Z12+Z1	N/A:B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	245,429	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg	N/A	39,10a	2
Income Stat. General Serv.	1,332,088	equal to	1,332,088	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,358,668	equal to	4,358,668	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,093,944	equal to	2,093,944	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,405,818	equal to	1,405,818	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	346,800	equal to	346,800	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H2	N/A	38to41+43	4
Income Stat. Prov. Partic.	114,383	equal to	114,383	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,788,582	equal to	2,921,867	-133,285	FAILED	Pg20 K11..K1	A.	5,24,25,27-:	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	175,318	equal to	175,318	0	O.K.	Pg20 K19+K:	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	64,059	equal to	64,059	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	287,006	equal to	287,006	0	O.K.	Pg20 K22..K	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	69,117	equal to	69,117	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	272,880	equal to	272,880	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	58,274	equal to	58,274	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	166,178	equal to	166,178	0	O.K.	Pg20 K30..K	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	528,704	equal to	528,704	0	O.K.	Pg20 K33..K	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,543,403	equal to	4,543,403	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,339	< or = to	11,339	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	25,500	< or = to	25,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	150,631	< or = to	187,145	-36,514	O.K.	Pg20 X14..X	B. & C.	o39 and 50t	2	Pg3 G19	N/A	10	3
Activity Consultant	4,310	< or = to	4,310	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,188	< or = to	2,188	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	166,178	equal to	166,178	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	404,756	equal to	404,756	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	59,290	equal to	59,290	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	690,472	equal to	690,472	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Professional fees - pg. 3, column 8/Sc	66,558	equal to	66,558	0	all good								
Supp. Sched.- Sched of dues..	48,334	equal to	48,334	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	7,270	equal to	7,270	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	114,383	equal to	114,383	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	10,623	< or = to	72,802	-62,179	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	10,623	equal to	10,623	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	9,080	equal to	9,505	-425	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-855,629	equal to	-855,629	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 61	B.	14	8
Total loan balance	7,106,390	equal to	7,106,390	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V:	N/A	29+39-41	2
Real estate tax accrual	141,000	equal to	141,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	511,025	equal to	511,025	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,877,304	equal to	6,877,304	0	O.K.	Pg12 to 12I	B.	36	4	Pg17 K26+K:	N/A	14 & 15	2
Equipment and vehicle cost	825,368	equal to	825,368	0	O.K.	Pg13 O22+L:	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,206,155	equal to	2,206,155	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-782,858	equal to	-782,858	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	36,672	equal to	36,672	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J:	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,851,455	equal to	1,851,455	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

ok, \$245,429 on pg. 16

ok, rehab aids on pg. 20, row 8 for \$133,285

Ok, includes \$36,514 of oxygen, med equip rental & rehab

ok

Ok, medicare days 9,080

[illegible][illegible]

Table Information Modules			
Year	General	General	General
1983	1 174	1 174	1 174
1984	1 174	1 174	1 174
1985	1 174	1 174	1 174
1986	1 174	1 174	1 174
1987	1 174	1 174	1 174
1988	1 174	1 174	1 174
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2060	1 174	1 174	1 174
2061	1 174	1 174	1 174
2062	1 174	1 174	1 174
2063	1 174	1 174	1 174

Total:

2004	2005	2006	2007
20.73	2.000	0	0.000
21.77	2.000	2	0.000
26.73	2.000	3	0.000
31.77	2.000	4	0.000
27.83	2.000	5	0.000
31.76	0.070	6	0.000
31.76	0.070	7	0.000
31.76	0.070	8	0.000
30.77	0.070	9	0.000
30.00	0.000	10	0.000

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Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100
2000	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100

100%

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	287,006	38,240	11,339	336,585	0	336,585	0	336,585
2. Food Purchase	0	245,030	0	245,030	0	245,030	-10,948	234,082
3. Housekeeping	272,880	27,236	0	300,116	0	300,116	354	300,470
4. Laundry	58,274	18,836	0	77,110	0	77,110	-5,486	71,624
5. Heat and Other Utilities	0	0	193,809	193,809	0	193,809	3,545	197,354
6. Maintenance	69,117	0	110,321	179,438	0	179,438	2,606	182,044
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	687,277	329,342	315,469	1,332,088	0	1,332,088	-9,929	1,322,159
9. Medical Director	0	0	25,500	25,500	0	25,500	0	25,500
10. Nursing & Medical Records	2,921,867	210,509	187,145	3,319,521	0	3,319,521	0	3,319,521
10a. Therapy	0	0	747,181	747,181	0	747,181	0	747,181
11. Activities	175,318	20,591	4,310	200,219	0	200,219	0	200,219
12. Social Services	64,059	0	2,188	66,247	0	66,247	0	66,247
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,161,244	231,100	966,324	4,358,668	0	4,358,668	0	4,358,668
17. Administrative	166,178	0	404,756	570,934	0	570,934	-404,756	166,178
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	59,290	59,290	0	59,290	7,268	66,558
20. Fees, Subscriptions & Promotion	0	0	47,558	47,558	0	47,558	776	48,334
21. Clerical & General Office	528,704	42,494	24,415	595,613	0	595,613	20,896	616,509
22. Employee Benefits & Payroll	0	0	617,670	617,670	0	617,670	72,802	690,472
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	4,580	4,580	0	4,580	2,690	7,270
25. Other Admin. Staff Trans	0	0	182	182	0	182	8,884	9,066
26. Insurance-Prop.Liab.Malpractice	0	0	198,117	198,117	0	198,117	3,479	201,596
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	694,882	42,494	1,356,568	2,093,944	0	2,093,944	-287,961	1,805,983
29. Total General Administrative	4,543,403	602,936	2,638,361	7,784,700	0	7,784,700	-297,890	7,486,810
30. Depreciation	0	0	33,031	33,031	0	33,031	235,981	269,012
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	38,061	38,061	0	38,061	356,792	394,853
33. Real Estate	0	0	0	0	0	0	132,968	132,968
34. Rent - Facility & Grounds	0	0	1,327,724	1,327,724	0	1,327,724	-1,327,724	0
35. Rent - Equipment & Vehicles	0	0	7,002	7,002	0	7,002	3,857	10,859
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,405,818	1,405,818	0	1,405,818	-598,126	807,692
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	245,429	0	245,429	0	245,429	0	245,429
40. Barber and Beauty Shop	0	0	29,364	29,364	0	29,364	0	29,364
41. Coffee and Gift Shops	0	0	6,762	6,762	0	6,762	0	6,762
42. Provider Participation	0	0	114,383	114,383	0	114,383	0	114,383
43. Other (specify):*	0	0	65,245	65,245	0	65,245	-65,245	0
44. Total Special Cost Ce	0	245,429	215,754	461,183	0	461,183	-65,245	395,938
45. Grand Total	4,543,403	848,365	4,259,933	9,651,701	0	9,651,701	-961,261	8,690,440

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	90,962	93,097
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	1,483,461	1,483,461
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	52,910	52,910
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	19,786	19,786
9. Other (specify):	0	31,591
10. Total current assets	1,647,119	1,680,845
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	8,566	8,566
13. Land	0	511,025
14. Buildings, at Historical Cost	0	6,418,908
15. Leasehold Improvements, Historical Cost	180,195	458,396
16. Equipment, at Historical Cost	174,023	825,368
17. Accumulated Depreciation (book methods)	-171,774	-2,206,155
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	13,326	66,989
24. Total Long-Term Assets	204,336	6,083,097
25. Total Assets	1,851,455	7,763,942
CURRENT LIABILITIES		
26. Accounts Payable	403,088	403,088
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	1,522,282	1,522,282
30. Accrued Salaries Payable	197,971	197,971
31. Accrued Taxes Payable	52,813	52,813
32. Accrued Real Estate Taxes	0	141,000
33. Accrued Interest Payable	0	31,411
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	458,159	108,764
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,634,313	2,457,329
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	5,584,108
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	5,584,108
46. Total Liabilities	2,634,313	8,041,437
47. Total Equity	-782,858	-277,495
48. Total Liabilities and Equity	1,851,455	7,763,942

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,879,485
2. Discounts and Allowances for all Levels	-877,097
Subtotal - Inpatient Care	8,002,388
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,244,780
7. Oxygen	0
Subtotal - Ancillary Revenue	1,244,780
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	7,842
13. Barber and Beauty Care	31,992
14. Non-Patient Meals	325
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	308,298
18. Sale of Supplies to Non-Patients	0
19. Laboratory	25,695
20. Radiology and X-Ray	11,694
21. Other Medical Services	48,209
22. Laundry	5,486
Subtotal - Other Operating Revenue	439,541
24. Contributions	0
25. Interest and Other Investments Income	2
Subtotal - Non-Operating Revenue	2
27. Other Revenue (specify):	1,662
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,662
30. Total Revenue	9,688,373
31. General Services	1,332,088
32. Health Care	4,358,668
33. General Administration	2,093,944
34. Ownership	1,405,818
35. Special Cost Centers	346,800
35. Provider Participation Fee	114,383
37. Other	0
40. Total Expenses	9,651,701
41. Income Before Income Taxes	36,672
42. Income Taxes	0
43. Net Income or Loss for the Year	36,672

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23 Provider Participation fee is linked from page 4